NOTICES OF EXEMPT RULEMAKING

The Administrative Procedure Act requires the *Register* publication of the rules adopted by the state's agencies under an exemption from all or part of the Administrative Procedure Act. Some of these rules are exempted by A.R.S. §§ 41-1005 or 41-1057; other rules are exempted by other statutes; rules of the Corporation Commission are exempt from Attorney General review pursuant to a court decision as determined by the Corporation Commission.

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

PREAMBLE

1. Sections Affected **Rulemaking Action**

R9-22-711 Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rule is implementing (specific):

Authorizing statute: A.R.S. § 36-2903.01

Implementing statute: Laws 2003, Ch. 265

3. The effective date of the rules:

October 1, 2003

4. A list of all previous notices appearing in the Register addressing the exempt rule:

Not applicable

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Barb Ledder

Address: AHCCCS
Office of Policy Analysis and Coordination
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4580

Fax: (602) 253-9115

6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from the regular rulemaking procedures:

The Administration has amended rules to comply with state statute, A.R.S. § 36-2903.01, which requires AHCCCS to promulgate rules for the implementation of Cost Sharing payments for certain AHCCCS eligible members. The rule prescribes the copayment requirements and the premium amounts for certain eligibility groups. The rulemaking is exempt from the provisions of Title 41, Chapter 6 under Laws 2003, Ch. 265, § 54.

7. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on in its evaluation of or justification for the rule or proposes not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The Administration did not review any study relevant to this rule.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

Not applicable

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

Not applicable

11. A summary of the principal comments and the agency response to them:

PRINCIPLE COMMENTS	AHCCCS RESPONSE
Suzi Berman, Executive Director of Pharmacy Value Options, INC. Does pharmacy copays suggest that consumers will have a choice between a branded or generic product? Almost all of the health plans that serve TXIX population have a mandatory generic policy in place, therefore branded products that have generic equivalents will generally reject at the pharmacy level with a message to use the generic product. Can you please clarify the proposed changes for prescription copayments.	The health plan practice regarding pharmacy management has not changed. A member is not allowed to pay the higher amount to have brand name medication. However, most health plans have brand name medication available as off formulary which would require prior authorization. Allowing members to get the brand medication if they are willing to pay a higher copayment could potentially drive up the cost of pharmaceuticals.
Mike Fett, Southwest Behavioral Health Services In R9-22-711(D) change "Physician Office Visit" to "Provider Office Visit" to allow the inclusion of independent billers, nurse practitioners, physician assistants, psychologists etc.	**Agree** AHCCCS believes that "Physician Office Visit" provides the clarity for copayments.
Bruce Semingson, United Drug & Eddie Sissions, Morris Institute for Justice wanted us to clarify R9-22-711(F) and the use of "shall" since some copays are not mandatory.	**Agree** AHCCCS clarified the language in R9-22-711(F).
Bruce Semingson, United Drug & Kathy Boyle, Az Pharmacy R 9-22-711(E) identifies the individuals who are subject to specific brand and generic copayments and that the provider may deny a service if the member does not pay the required copayment. What are the implications to the pharmacy if they deny service?	The implications for the pharmacy are the same as if any other person with another type of insurance would not have the money to pay the copay.
Bruce Semingson, United Drug Federal Regulations prohibit pharmacies from collecting copayments from Medicaid population when the individual refuses or is unable to pay the copayment. Does A.R.S. § 36-2903.01 meet the federal standard? Has it been waived? If an individual refuses or is unable to pay the copayment what actions may the pharmacy take regarding prescription services? Can they deny services?	Federal law prohibits services to be denied for the categorical "entitled" groups under R9-22-711 (D). However, services can be denied if copayments are not made by the non-categorical groups under R9-22-711(E).
Suzanne Rabideau, ADHS DHS requests that individuals enrolled in behavioral health be exempt from ALL copayments.	AHCCCS did not increase the copayments for persons enrolled in behavioral health. The copayments are the same as they were before these rules.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rules:

No incorporations by reference

14. Was this rule previously adopted as an emergency rule?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-711. Copayments

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-711. Copayments

~~**A.** Except as provided in subsection (B) contractors and members shall comply with the following copayment schedule:~~

A. For purposes of this Article:

1. A copayment is a monetary amount that a member pays directly to a provider at the time a covered service is rendered.
2. An eligible individual is assigned to a hierarchy established in subsections (B) through (E), for the purposes of establishing a copayment amount.
3. A copayment is assessed prospectively. No refunds shall be made for a retroactive period if there is a change in a person's status altering the amount of a copayment.
4. Family planning services and supplies are exempt from copayments for all members.

B. The following individuals are exempt from all AHCCCS copayments:

1. An individual under age 19 including individuals eligible for the KidsCare Program in A.R.S. § 36-2982;
2. An individual determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services;
3. A Native American eligible under the parent program in A.R.S. § 36-2981.01;
4. A Native American enrolled with IHS;
5. An eligible individual not enrolled with a contractor and classified as fee-for-service;
6. A pregnant woman eligible for any AHCCCS program;
7. An individual eligible for the family planning services program in A.R.S. § 36-2907.04;
8. An individual eligible for the Arizona Long Term Care Program in A.R.S. § 36-2931;
9. An individual eligible for Medicare Cost Sharing in A.R.S. § 36-2972; and
10. An individual eligible for the Children's Rehabilitative Services program under A.R.S. § 36-2906(E).
11. An institutionalized person under R9-22-216.

C. Unless otherwise listed subsection (B), an individual eligible for the parent program in A.R.S. § 36-2981.01 is subject to a $5.00 per visit copayment for a nonemergency use of the emergency room. A provider shall not deny service because of the member's inability to pay a copayment.

D. Unless otherwise listed in subsections (B) or (C), the following individuals are subject to the copayments listed in this subsection. A provider shall not deny a service because of the member's inability to pay a copayment.

1. A family eligible under Section 1931 of the Act;
2. An individual eligible for Young Adult Transitional Insurance (YATI) in A.R.S. § 36-2901(6)(iii);
3. An individual eligible for State Adoption Assistance in R9-22-1426;
4. An individual eligible for Supplemental Security Income (SSI);
5. An individual eligible for SSI Medical Assistance Only (SSI/MAO) in R9-22-1500;
6. An individual eligible for the Transitional Medical Assistance (TMA) in A.R.S. § 36-2924;
7. An individual eligible for the Freedom to Work program in A.R.S. § 36-2901(6)(g); and
8. An individual eligible for the Breast and Cervical Cancer Treatment program in A.R.S. § 36-2901.05.
9. An individual enrolled for behavioral health services in A.R.S. § 36-2907.

Covered Services	**Copayment**
~~Doctor's office or home visit and all diagnostic and rehabilitative x-ray and laboratory services associated with the visit~~ Physician office visit	$1.00 per office visit
~~Nonemergency surgery~~	~~$5.00 per procedure~~
Nonemergency use of the emergency room.	$5.00 per visit

E. Unless otherwise listed in subsection (B), (C), or (D), the following individuals are required to pay the copayments listed in this subsection. The provider may deny a service if the member does not pay the required copayment.

1. An individual whose income is under 100% of the Federal Poverty Level in A.R.S. § 36-2901.01, or
2. An individual eligible for the Medical Expense Deduction program in A.R.S. § 36-2901.04.

Covered Services	**Copayment**
Generic prescriptions or brand name prescriptions if generic is not available	$4.00 per prescription
Brand name prescriptions when generic is available	$10.00 per prescription
Nonemergency use of the emergency room	$30.00 per visit
Physician office visit	$5.00 per office visit

~~**B.** AHCCCS registered providers shall collect copayments from members. The following are excluded from copayment requirements:~~
~~1. Prenatal care including all obstetrical visits;~~
~~2. Well-baby and E.P.S.D.T. care;~~
~~3. Care in a nursing facility or ICF/MR;~~
~~4. Visits scheduled by a primary care physician, attending physician, or practitioner, and not at the request of the member;~~
~~5. Drugs and medications beginning October 1, 1985; and~~
~~6. Family planning services.~~
~~**C.** A contractor or the Administration shall ensure that a member is not denied services because of the member's inability to pay a copayment.~~
F. A provider is responsible for collecting any copayment.

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM CHILDREN'S HEALTH INSURANCE PROGRAM

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-31-303	Amend
R9-31-307	Amend
R9-31-711	Amend
R9-31-1402	Amend
R9-31-1415	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 36-2903.01 and 36-2983

Implementing statute: Laws 2003, Ch. 265

3. The effective date of the rules:

October 1, 2003

4. A list of all previous notices appearing in the Register addressing the exempt rules:

Not applicable

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Barb Ledder

Address: AHCCCS
Office of Policy Analysis and Coordination
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4580

Fax: (602) 253-9115

6. An explanation of the rules, including the agency's reasons for initiating the rules, including the statutory citation to the exemption from the regular rulemaking procedures:

The Administration has amended rules to comply with state statute, A.R.S. § 36-2903.01, which requires AHCCCS to promulgate rules for the implementation of cost sharing and premiums. The rulemaking is exempt from the provisions of Title 41, Chapter 6 under Laws 2003, Ch. 265, § 54.

7. A reference to any study relevant to the rules that the agency reviewed and either proposes to rely on in its evaluation of or justification for the rules or proposes not to rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The Administration did not review any study relevant to these rules.

8. A showing of good cause why the rules are necessary to promote a statewide interest if the rules will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

Not applicable

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

Not applicable

11. A summary of the principal comments and the agency response to them:

PRINCIPLE COMMENTS	AHCCCS RESPONSE
Eddie Sissions, Morris Institute for Justice R9-31-711---- Need to clarify the language. Some individuals are not required to pay a copay.	**Agree** AHCCCS clarified language.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rules:

No incorporations by reference

14. Were these rules previously adopted as emergency rules?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM CHILDREN'S HEALTH INSURANCE PROGRAM

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

Section
R9-31-303. Eligibility Criteria
R9-31-307. Guaranteed Enrollment

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-31-711. Copayments ~~and Premiums~~

ARTICLE 14. PREMIUMS

Section
R9-31-1402. Premium Amount for a Member who is a Child Determined Eligible Under Article 3 of This Chapter
R9-31-1415. Payment Reimbursement

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-31-303. Eligibility Criteria

Eligibility. To be eligible for the program, an applicant shall meet all the following eligibility requirements:

1. Age. Is under 19 years of age. A child's coverage shall continue through the month in which a child turns age 19 if the child is otherwise eligible;
2. Citizenship. Is a United States citizen or a qualified alien under A.R.S. § 36-2983;
3. Residency. Is a resident of the state of Arizona under A.R.S. § 36-2983. An Arizona resident is a person who currently lives in Arizona and intends to remain in Arizona indefinitely;
4. Income. Meets the income requirements in R9-31-304;
5. Cost sharing. Pays the cost sharing premium amount when premiums are required as specified in A.R.S. §§ 36-2982 and 2903.01;
6. Social security number. The Administration shall not deny eligibility for Title XXI if an applicant does not provide or apply for a social security number except as specified under A.R.S. § 36-2983.
7. Assignment. Assigns rights to any first- or third-party coverage of medical care as specified in 9 A.A.C. 31, Article 10;
8. Other federal program. Is not eligible for Title XIX or other federally operated or financed health care insurance program, except the Indian Health Service as specified in A.R.S. § 36-2983;
9. Inmate of a public institution. Is not an inmate of a public institution, as specified in A.R.S. § 36-2983;
10. Patient in an institution for mental disease. Is not a patient in an institution for mental disease at the time of application, or at the time of redetermination, as specified in A.R.S. § 36-2983;
11. Other health coverage. Is not covered under:
    a. An employer's group health insurance plan,
    b. Family or individual health insurance, or
    c. Other health insurance;
12. State health benefits. Is not a member of a family that is eligible for health benefits coverage under a state health benefit plan based on a family member's employment with a public agency in the state of Arizona;
13. Prior health insurance coverage. Has not been covered by health insurance during the previous three months unless that health insurance was discontinued due to the involuntary loss of employment or other involuntary reason as specified in A.R.S. § 36-2983. The three months of ineligibility due to previous insurance coverage shall not apply to:
    a. A newborn as defined in R9-31-309;
    b. A Title XIX member as specified in 9 A.A.C. 22, Article 1;
    c. An applicant who is seriously ill under R9-31-101 or chronically ill under A.R.S. § 36-2983;
    d. A Title XXI member who loses insurance coverage;
    e. A CRS member; or
    f. A Native American member receiving services from IHS or a Tribal Facility.

R9-31-307. Guaranteed Enrollment

A. Guaranteed Enrollment. A child who is determined eligible for Title XXI shall be guaranteed a one-time, 12-month period of continuous coverage unless a child:
1. Attains age 19,
2. Is no longer a resident of the state,
3. Is an inmate of a public institution,
4. Is determined to have been ineligible at the time of approval,
5. Obtains private or group health coverage,
6. Is adopted and the new household does not meet the qualifications of this program,
7. Is a patient in an institution for mental diseases,
8. Has whereabouts that are unknown, or
9. Has a head of household who:
    a. Does not pay cost sharing premium amount when premiums are required as specified in A.R.S. §§ 36-2982 and 2903.01 and as specified in this Chapter,
    b. Voluntarily withdraws from the program, or
    c. Fails to cooperate in meeting the requirements of the program.

B. The 12-month guaranteed period shall begin with the month an applicant is initially enrolled.

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-31-711. Copayments ~~and Premiums~~

~~**A.** Contractors shall collect a $5.00 copayment from a member for non-emergency use of the emergency room.~~

~~**B.** A contractor shall ensure that a member is not denied services because of the member's inability to pay a copayment.~~

~~**C.** The Administration addresses standards for premiums under 9 A.A.C. 31, Article 14.~~

An individual determined eligible under this Chapter shall comply with R9-22-711.

ARTICLE 14. PREMIUMS

R9-31-1402. Premium Amount for a Member who is a Child Determined Eligible Under Article 3 of This Chapter

A. For the purposes of this Article, a premium is a monthly amount that an enrolled member pays to the Administration to remain eligible for Title XIX or XXI.

~~**A.**~~**B.** When household income is greater than 150 percent of the FPL and less than or equal to 175 percent of the FPL, the monthly premium payment is $10 for ~~a household with~~ one ~~member~~ eligible child and $15 for ~~a household with more than one member~~ two or more eligible children.

~~**B.**~~**C.** When household income is greater than 175 percent of the FPL and less than or equal to 200 percent of the FPL, the monthly premium is $~~15~~20 for ~~a household with~~ one ~~member~~ eligible child and $~~20~~25 for ~~a household with more than one member~~ two or more eligible children.

~~**C.**~~**D.** A household's premium payments as specified in this Section and R9-31-1408, when combined with a household's copayments as specified in ~~R9-31-711~~ R9-22-711, shall not exceed five percent of a household's gross income.

~~**D.**~~**E.** A member's newborn is enrolled immediately upon the Administration receiving notification of the child's birth. Upon enrollment, the household's premium is redetermined.

R9-31-1415. Payment Reimbursement

~~When a premium is paid for more than one month at a time, and a member is subsequently determined ineligible for the program, the Administration shall reimburse the member for any months of coverage not used except as specified in R9-31-1419 of this Article.~~

A premium paid in advance is nonrefundable, unless the member is disenrolled at least 15 days prior to the month of coverage. A premium paid during a grievance, appeal or request for hearing under R9-31-1419 is nonrefundable.